



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Universal DME LLC

Respondent Name

Zurich American Insurance Co

MFDR Tracking Number

M4-16-0137-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have enclosed all supporting documents proving that this is related to the work injury along with authorization from Zurich Insurance. We have submitted the appropriate paperwork for your review and are indeed due this amount."

Amount in Dispute: \$1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has dispute the bill based on "Claim lacks information or has submission/billing errors which is needed for adjudication." Request resubmitted its bill but had not amended the bill to correct the errors. Carrier maintains that reimbursement is not owed.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2015	E0676	\$1,500.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - W3 – In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal

Issues

1. Is there an applicable fee schedule for the service in dispute?
2. What is the applicable rule that pertains to reimbursement?
3. Is additional reimbursement due?

Findings

1. 28 Texas Administrative Code §134.203. Medical Fee Guideline for Professional Services(d) states,
The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
 - (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
 - (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
 - (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

Review of the submitted documentation finds no DMEPOS fee schedule amount for the services in dispute nor does the Medicaid (TMHP) find an allowable. Therefore the disputed charges will be reviewed based on fair and reasonable guidelines.

2. 28 Texas Administrative Code §134.1(f) Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

3. 28 Texas Administrative Code §133.307(c)(2)(O), requires "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

28 Texas Administrative Code §134.1 states,

(f) Fair and reasonable reimbursement shall:

- (1) be consistent with the criteria of Labor Code §413.011;
- (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
- (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Review of the submitted documentation finds that:

- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested

reimbursement.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	October , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.